THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-6504.M5

MDR Tracking Number: M5-04-1774-01

A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 17, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The Hydrocodone/Apap and Neurontin for 02-17-03 **were** found to be medically necessary. The Carisoprodol for 02-17-03 **was not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to date of service 02-17-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 11th day of May 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

April 26, 2004
Amended May 6, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-1774-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy board certified in anesthesiology and specialized in pain management. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ reported a work-related injury in ___, a result of unloading his truck. At that time he noted immediate sharp pain with radiation to both hips and down the right leg to the toes. Since his date of injury he has been treated with medication and apparently had injection therapy to the lumbar spine. Pain problems seem to continue along wit the use of Hydrocodone/Apap, Carisoprodol and Neurontin. The continued use of medications is the focus of this review.

DISPUTED SERVICES

Under dispute is the medical necessity of Hydrocodone/Apap, Carisoprodol and Neurontin.

DECISION

The reviewer agrees with the prior adverse determination regarding the medication Carisprodol. However, the reviwer disagrees with the prior adverse determination regarding the Hydrocodone/Apap and Neurontin.

BASIS FOR THE DECISION

Carisprodol is neither reasonable nor necessary for treatment in this case. Hydrocodone/Apap and Neurontin are many times necessary for treatment of chronic back pain issues involving chronic radiculitis from diffuse lumbar degenerative disc disease, as appears to be present in this case.

This patient's initial complaint involved low back, bilateral hip and thigh pain along with radiation down the right leg to the toes. A February 21, 2003 report from ___ includes a NCV study indicative of right lu radiclpathy along with MRI findings of 8/9/01 demonstrating L4/5 bulge, L5/S1 disc protrusion along with annular tear at L1/2, L2/3, L4/5, L5/S1. It is well known the chemical neuritis form annular tears can lead to chronic lumbar and radicular pain issues. Combinations of analgesics and neuromodalatory drugs can be valuable tools in improving lifestyle and functional ability in such cases until such time as a more definitive therapy can be employed, if that is such an option.

Regarding the continued use of Carisprodol, there are muscle relaxants that have less propensity to cause sedation that may be used sporadically for muscle spasm issues.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,